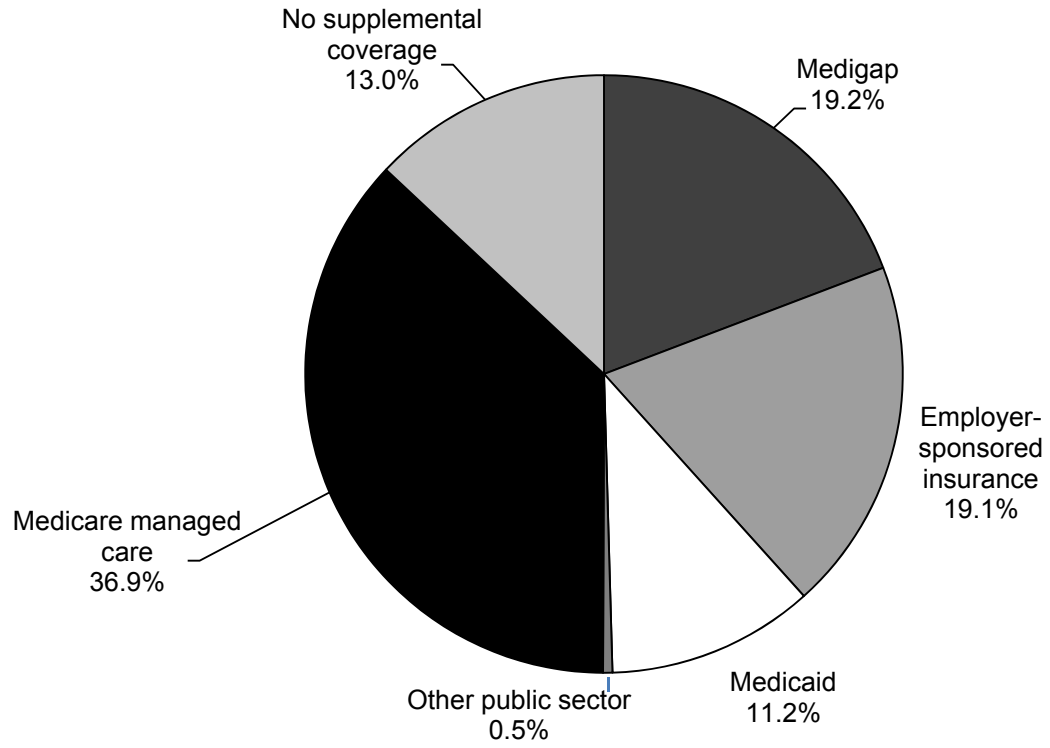
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2015



Note: Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2015. They could have had coverage in other categories during 2015. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2015 or who had Medicare as a secondary payer. Percentages do not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2015.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2015, 87 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.
- About 38 percent of beneficiaries had private sector supplemental coverage such as medigap (about 19 percent) or employer-sponsored retiree coverage (about 19 percent).
- About 12 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.
- About 37 percent of beneficiaries participated in Medicare managed care. This care includes Medicare Advantage, health care prepayment, and cost plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often add more coverage.
- The numbers in this chart differ from those in Chart 2-5, Chart 4-1, and Chart 4-4 because of differences in the populations represented in the charts. This chart excludes beneficiaries in long-term care institutions, while Chart 2-5 and Chart 4-4 include all Medicare beneficiaries, and Chart 4-1 excludes beneficiaries in Medicare Advantage.

Chart 3-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2015

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**45,573**	**19%**	**19%**	**11%**	**37%**	**1%**	**13%**
Age							
<65	7,325	7	4	37	32	1	20
65–69	10,540	19	22	6	37	1	14
70–74	10,003	21	22	6	40	0	11
75–79	7,455	22	23	7	38	0	10
80–84	5,266	25	21	6	37	0	11
85+	4,984	23	23	6	36	0	11
Income-to-poverty ratio							
≤1.00	7,360	4	7	42	36	1	11
1.00 to 1.25	3,816	6	12	28	39	0	14
1.25 to 1.50	3,117	9	18	17	39	1	17
1.50 to 2.00	5,874	14	19	5	43	1	19
>2.00	25,357	28	24	1	35	0	12
Eligibility status							
Aged	38,096	21	22	6	38	0	12
Disabled	7,108	7	4	37	32	1	19
ESRD	369	14	15	27	14	5	24
Residence							
Urban	36,061	19	18	10	40	1	12
Rural	9,496	20	24	15	23	0	17
Sex							
Male	20,142	19	18	11	36	1	16
Female	25,431	19	20	12	38	1	11
Health status							
Excellent/very good	20,187	23	23	5	38	0	11
Good/fair	21,789	17	17	14	37	1	14
Poor	3,288	8	10	29	33	1	20

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2015. They could have had coverage in other categories during 2015. "Medicare managed care" includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs) as indicated by core-based statistical areas. "Rural" indicates beneficiaries living outside MSAs, which includes both micropolitan statistical areas and rural areas as indicated by core-based statistical areas. Analysis excludes beneficiaries living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2015 or who had Medicare as a secondary payer. The number of beneficiaries differs among boldface categories because we excluded beneficiaries with missing values. Numbers in some rows do not sum to 100 percent because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2015.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are age 65 or older, have income above twice the poverty level, are eligible because of age, and report better than poor health.
- Medigap is most common among those who are age 65 or older, have income higher than 1.25 times the poverty level, are eligible because of age, are rural dwelling, and report better than poor health.
- Medicaid coverage is most common among those who are under age 65, have income lower than 1.5 times the poverty level, are eligible because of disability or ESRD, are rural dwelling, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, are eligible because of disability or ESRD, are rural dwelling, are male, and report poor health.

Chart 3-3. Covered benefits and enrollment in standardized medigap plans, 2016

	Medigap standardized plan type										
						High deductible					
Benefit	A	B	C	D	F	F	G	K	L	M	N
Part A hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B cost sharing	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	$20/$50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice cost sharing	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible			✓		✓	✓					
Part B excess charges					✓	✓	✓				
Foreign travel emergency			✓	✓	✓	✓	✓			✓	✓
Lives covered (in thousands)	150	275	900	175	6,700	250	1,300	75	50	5	1,100
Percent change 2015–2016	5%	–7%	–9%	–8%	7%	13%	42%	2%	–1%	325%	18%

Note: SNF (skilled nursing facility). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The ✓ indicates that the plan covers all cost sharing. Percentages indicate that the plan covers that share of the total cost sharing. The $20/$50 indicates that the plan covers all but $20 for physician office visits and all but $50 for emergency room visits.

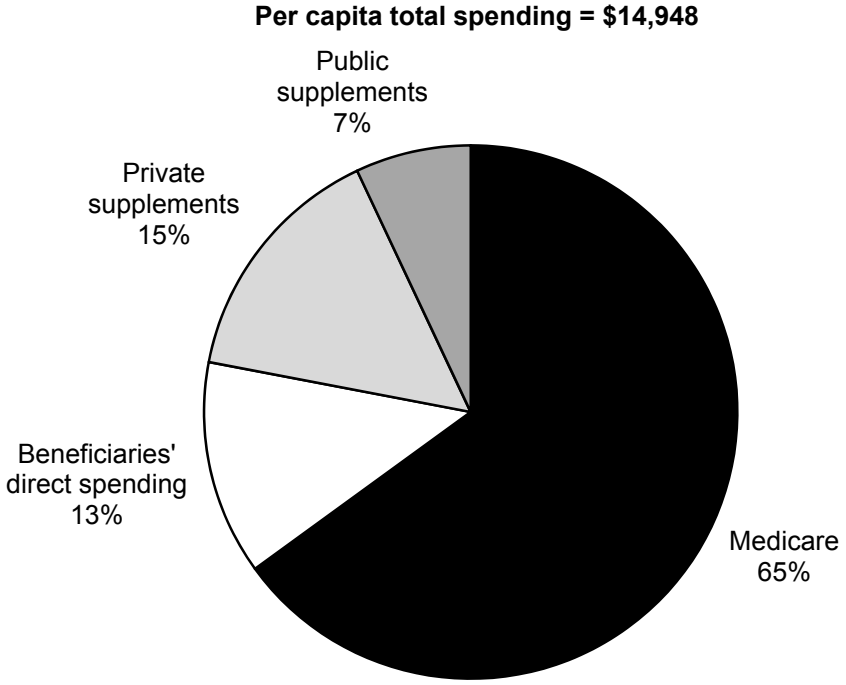
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2017.

- Medicare beneficiaries purchase medigap plans, also known as Medicare supplementary insurance plans, to cover fee-for-service Medicare cost sharing. Statute specifies 11 standardized plans. States enforce the standards based on model regulations developed by the National Association of Insurance Commissioners (NAIC). Three states (Massachusetts, Minnesota, and Wisconsin) have waivers from these standards and have different standard plan types not included in this chart.

- Plan F, which covers all Medicare cost sharing, is the most popular plan, with 6.7 million enrollees. However, because Congress was concerned about the overutilization of Medicare services, legislation will prohibit the sale of new Plan F policies beginning in 2020. As a result, insurers have begun to direct beneficiaries into other plan types, namely plans G, M, and N, which do not cover the Part B deductible.

- During 2016, more than 12 million beneficiaries enrolled in medigap plans. Of all Medicare beneficiaries, about one-fifth were enrolled in medigap plans. Charts 3-1 and 3-2 indicate that about 8.8 million beneficiaries (19.2 percent of 45.6 million beneficiaries) had medigap coverage in 2015. The discrepancy in medigap enrollment between this chart and Charts 3-1 and 3-2 occurs because this chart includes all Medicare beneficiaries while Charts 3-1 and 3-2 exclude beneficiaries living in long-term institutions, those who did not have both Part A and Part B coverage throughout their Medicare enrollment in 2015, and those who had Medicare as a secondary payer. In addition, this chart is based on data from 2016, while Charts 3-1 and 3-2 are based on data from 2015.

Chart 3-4. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2013



Note: FFS (fee-for-service). "Private supplements" includes employer-sponsored plans and individually purchased coverage. "Public supplements" includes Medicaid, Department of Veterans Affairs, and other public coverage. "Beneficiaries' direct spending" is on Medicare cost sharing and noncovered services, but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes. We excluded Medicare Advantage enrollees.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, ONLY PART OF THE MEDICARE CURRENT BENEFICIARY SURVEY (MCBS), WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART, HAD BEEN RELEASED FOR 2015. THIS CHART REFLECTS MEDPAC ANALYSIS OF THE 2013 MCBS COST AND USE FILES, WHICH ARE THE MOST RECENT AVAILABLE. (THERE ARE NO MCBS DATA FOR 2014.) THE READER IS ADVISED TO CONSULT THE 2015 MCBS DIRECTLY, WHEN THE COMPLETE SURVEY BECOMES AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

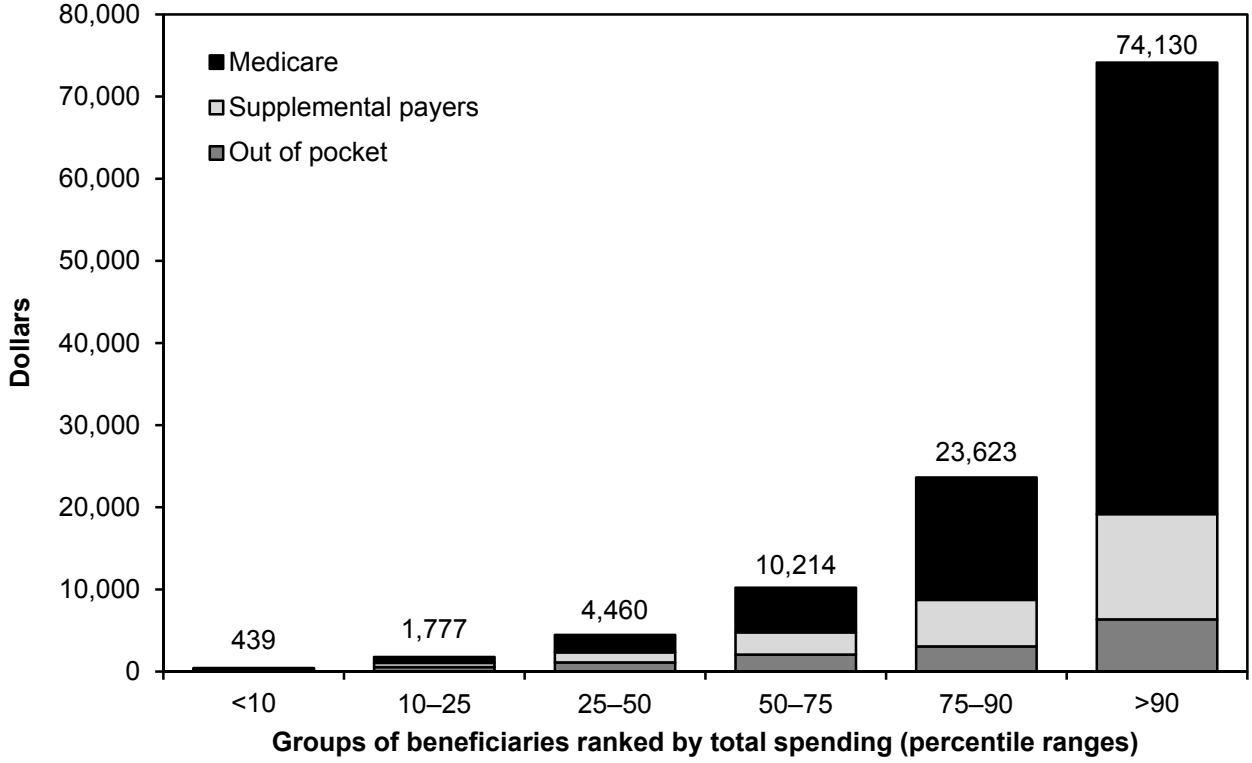
- Among FFS beneficiaries living in the community (noninstitutionalized), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $15,000 in 2013. Medicare was the largest source of payment: It paid about 65 percent of the health care costs for FFS beneficiaries living in the community, an average of $9,748 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.

- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid about 15 percent of beneficiaries' costs, an average of $2,198 per beneficiary.

- Beneficiaries paid about 13 percent of their health care costs out of pocket, an average of $1,993 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid about 7 percent of beneficiaries' health care costs, an average of $1,009 per beneficiary.

Chart 3-5. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2013



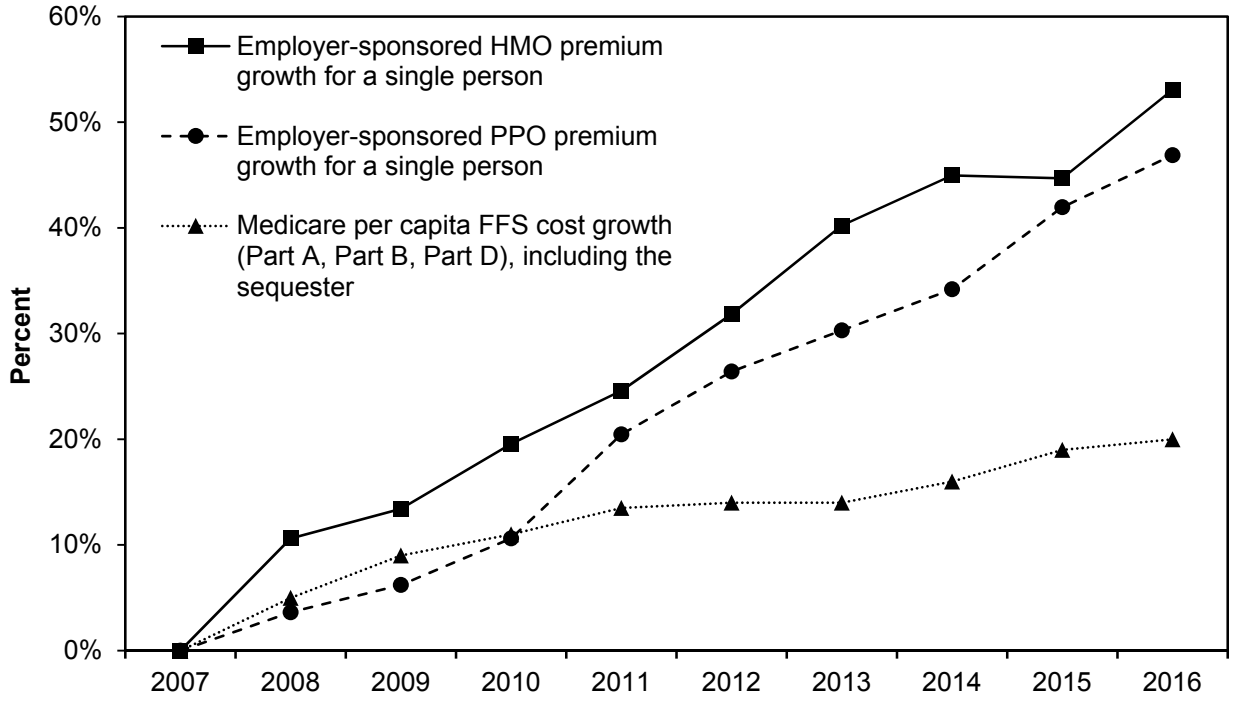
Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. “Out-of-pocket" spending includes Medicare cost sharing and noncovered services.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, ONLY PART OF THE MEDICARE CURRENT BENEFICIARY SURVEY (MCBS), WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART, HAD BEEN RELEASED FOR 2015. THIS CHART REFLECTS MEDPAC ANALYSIS OF THE 2013 MCBS COST AND USE FILES, WHICH ARE THE MOST RECENT AVAILABLE. (THERE ARE NO MCBS DATA FOR 2014.) THE READER IS ADVISED TO CONSULT THE 2015 MCBS DIRECTLY, WHEN THE COMPLETE SURVEY BECOMES AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2013. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $74,130. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $439.

- Among FFS beneficiaries living in the community, Medicare paid a larger share as total spending increased, and beneficiaries’ out-of-pocket spending was a smaller share as total spending increased. For example, Medicare paid 65 percent of total spending for all beneficiaries, but paid 77 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries’ out-of-pocket spending covered 13 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown).

Chart 3-6. Cost of employer-sponsored commercial insurance has grown more than twice as fast as Medicare costs



Note: HMO (health maintenance organization), PPO (preferred provider organization), FFS (fee-for-service). Medicare spending is reported including the effects of the sequester that began in March 2013, which reduced program spending by 2 percent.

Source: Employer-sponsored premium data are from Kaiser Family Foundation surveys, 2007 through 2016. Medicare spending figures are from Part A and Part B program spending data from CMS actuaries; Part D spending per capita figures through 2015 are from MedPAC analysis of claims and reinsurance data for individuals with Part D coverage. Part D spending for 2016 is a projection.

- Medicare costs have risen more slowly than commercial insurance premiums in part due to slower price growth for Medicare services.
- Per capita costs in FFS Medicare grew by 20 percent from 2007 to 2016. This 20 percent growth rate is the cumulative growth in the CMS actuaries' estimated cost of Part A and Part B benefits and the Commission's estimates of the cost of Part D premiums and reinsurance from 2007 to 2016. The Medicare FFS growth rate also was not adjusted for enhancements of the Part D benefit that included a shrinking of the coverage gap.
- In the commercial sector, employer-sponsored HMO premiums grew by 53 percent and PPO premiums by 47 percent over the same period, despite the rapidly increasing deductibles reported in the Kaiser Family Foundation survey. While deductibles grew rapidly for both employer-sponsored HMOs and PPOs, they tended to grow fastest for PPOs, possibly explaining why PPO premiums grew at a slightly slower rate than HMO premiums.
- None of the growth rates that we discuss have been adjusted for changes in demographics. We note that the average age of Medicare FFS beneficiaries declined by 0.3 years over this period.